

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-048729

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 419

FILED DEC 17 1963

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| 1. PLACE OF DEATH a. COUNTY Marion | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal | | c. CITY OR TOWN Hannibal Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital | | d. STREET ADDRESS (If outside, give location) 2710 Marsh Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or print) WILLIAM G. TURNER | | | 4. DATE OF DEATH Month December Day 7 Year 1963 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Oct 17, 1895 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Halls County, Mo. | |
| 12. CITIZEN OF WHAT COUNTRY U S A | | | | | |

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|--|--|--|--|--|--|
| 13a. FATHER'S NAME William P. Turner | | 13b. MOTHER'S MAIDEN NAME Amanda Krigbaum Bell | | 14. NAME OF HUSBAND OR WIFE Myrtle James | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Wm. G. Turner - Hannibal, Mo. | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency | | INTERVAL BETWEEN ONSET AND DEATH yrs. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) chr. pulmonary emphysema | | yrs. |
| DUE TO (c) emphysemateous blebs Spontaneous pneumothorax due to rupture of | | 1 month |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour 11:35 a.m. p.m. Month, Day, Year 11/6/63 | | | |

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|---|--|--|---------------------------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hannibal Marion Mo. | 20f. CITY, TOWN, OR LOCATION Hannibal Marion Mo. | COUNTY Marion STATE Mo. |
| 21. I attended the deceased from 11/6/63 to 12/7/63 and last saw her alive on 12/7/63 Death occurred at 11:35 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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| 22a. SIGNATURE <i>J. H. Wackerhausen M.D.</i> (Degree or title) | 22b. ADDRESS 1209 Broadway, Hannibal, Mo. | 22c. DATE SIGNED 12/10/63 |
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|--|------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12-10-63 | 23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Pk. | 23d. LOCATION (City, town, or county) Hannibal, Missouri |
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| 24. FUNERAL DIRECTOR Smith Funeral Home - Hannibal, Mo. | 25. DATE RECD. BY LOCAL REG. Dec. 10, 1963 | 26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Luchey</i> |
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

VS 300
Rev. 4/59

1 0648
2 0648
3
4 0
5 2
6
7 0
8 1
9 5271
10
11
12 2-0
13 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
 or by _____, Student Embalmer No. _____
 working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed *H. Crawford Smith*

Licensed Embalmer No. 3814

P. O. Address Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
 If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
 If this body is not embalmed, fact should be so stated above.

Permit received 12/10/63